STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011171	A. BUILDING: _____ B. WING _____	C 03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOME HEALTH AND HOSPICE CARE INC	79 S CR 700 W CUMBERLAND, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This visit was a state Home Health complaint investigation survey. Complaint number: IN00124865 - Substantiated: No deficiencies related to the allegation are cited. Survey date: March 20, 2013 Facility number: 011171 Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor American Home Health and Hospice Care Inc. is in compliance with the Indiana State Rules for home health licensure 410 IAC 17-12-3 and 17-13-1 as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN March 22, 2013	N 000		